AUTISM ATTESTATION NOTIFICATION

NAME:	**INDIVIDUAL NPI:**
DEGREE:	**TITLE:**
LICENSE STATE:	**LICENSE NUMBER:**
FEDERAL TAX I.D./EIN/FEIN/SSN:	**GROUP NPI:**
CLINIC PRACTICE NAME:	**APPT PHONE NUMBER:**
ADDRESS:	**CITY/STATE/ZIP:**

Please complete the following:

WI Autism Spectrum Disorder (ASD) Verification:

Is the outpatient mental health clinic approved by DHS with a signed Medicaid provider agreement to provide autism spectrum disorder services through the Medicaid Home and Community-based Services as granted by the Centers for Medicare & Medicaid Services (Waiver Program)?

_____ Yes _____ No

If yes, please provide documentation of this relationship and latest certification date: _____

If no, is the above provider a:

_____ Psychiatrist _____ Psychologist _____ Social Worker _____ Board-Certified Behavior Analyst

_____ Other: Non-intensive Autism Provider?

SECTION I: Providing Intensive or Intensive and Non-Intensive Level Services:

Psychiatrist/Psychologist/Social Worker/Board-Certified Behavior Analyst:

I certify that I have had at least 2,080 hours of practicing psychotherapy including at least 1,500 hours supervised training involving direct one-on-one work with individuals with ASD and including all the requirements as stated in 3.36 WI adm. code.

_____

Signature of Qualified Provider Date

SECTION II: Providing Non-Intensive Level Services Only:

Non-intensive Autism Provider:

I certify that I have a state license as defined in 3.36 WI adm. code and practice within the scope of a current valid license and that I am only providing non-intensive ASD services and working under the supervision of an outpatient mental health clinic certified under 51.038 statutes.

_____

Signature of Qualified Provider Date

Return completed form to:

Aspirus Health Plan, ATTN: Provider Relations
P.O. Box 1062 • Minneapolis, MN 55440 • Fax: 763.847.4010

Disclaimer: Please note that this is not a contract. This information is used solely to better allow Aspirus Health Plan to process claims.

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